Harvard Pilgrim Health Care

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Submitted to the Insurance and Real Estate Committee
SB 925, An Act Concerning The Cost Of Prescription Drugs And Value-Based Insurance Design
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Senator Larson, Senator Kelly, Representative Scanlon and members of the Insurance and Real Estate Committee, thank you for the opportunity to give testimony today on behalf of Harvard Pilgrim Health Care ("HPHC"). For those of you that are not aware, HPHC entered the Connecticut marketplace in 2014 and we have grown steadily, now providing insurance to roughly 32,000 Connecticut residents. We also offer coverage in Massachusetts, New Hampshire and Maine, and serve nearly 1.3 million members throughout New England. HPHC is currently Connecticut's only not-for-profit health plan, and our mission is to improve the quality and value of health care for the people and communities we serve. In fulfillment of this mission, we take seriously our role in keeping health insurance affordable and accessible for all our members. Unfortunately, regarding the topic of today's hearing - over the last three years, rising prescription drug costs have outpaced almost all other sectors of health care.

For this reason, I would like to begin my testimony by thanking Comptroller Lembo for proposing SB 925, which seeks to address the cost of prescription drugs from a variety of angles. HPHC would like to offer its strong SUPPORT of SECTIONS 5, 6 & 7, which seeks to bring much needed transparency into the issue of prescription drug prices. At the same time, we would like to address our OPPOSITION of SECTION 3, which places unnecessary requirements on health plans.

IN SUPPORT OF SECTIONS 5, 6 & 7 – Prescription Drug Transparency

As drafted, these sections of the legislation would require pharmaceutical manufacturers to disclose specific information to the state's Insurance Commissioner on how prices or price increases are determined. As written, these disclosures would be required of any new brand drug with a wholesale price exceeding $30,000 or any new generic formulation exceeding $3,000. Similarly, any brand drug with a year-over-year price increase exceeding 10% or $10,000 (whichever is greater) or generic drug with an increase of 25% or $300 would need to be reported.

While other states, such as Vermont, have established different thresholds triggering when a pharmaceutical manufacturer must report the state, HPHC urges that new-to-market drugs and generics with significant year-over-year increases are the focus of any transparency legislation, such as proposed in SB 925.

First, there is no doubt that transformative new drugs have revolutionized the treatment of a number of conditions from Hepatitis C to cancer. Unfortunately, the price of these medications have garnered as much attention as the benefit they provide to patients. Certainly, Sovaldi, with its initial $1,000-per-pill price, represents the most highly publicized example, despite its nearly 90% cure rate for Hepatitis C, type 1 – the most common form of Hepatitis C in America. Similarly, health plans continue to monitor the pipeline for new oncology medications. According to the Pharmaceutical Research and Manufacturers of America (PhRMA), 771 new drugs and vaccines are in development by US companies, including: 98 being developed for lung cancer; 87 for leukemia; 78 for lymphoma; 73 for breast cancer; 56 for skin cancer; and 48 for ovarian cancer. Yet, despite the promise presented

by these new drugs, according to a recent study by the Mayo Clinic, the average annual cost of oncology drugs increased from roughly $10,000 before the year 2000 to over $100,000 by 2012.[1] As another study noted, all new US Food and Drug Administration (FDA) cancer drugs approved in 2014 were priced above $120,000 per year of use.[2]

Second, while most have focused their attention on the high cost of specialty drugs, unexpected and significant price increases have also been occurring with generic drugs. For example, a 30 gram tube of generic topical ointment used to treat eczema and psoriasis cost roughly $8.00 in 2013. Today, the same 30 gram tube costs $180, a 2200% increase in just 3 years. Similarly, a common generic drug to treat congestive heart failure increased by nearly 820%, from $0.12 a tablet in 2013 to $0.98 a tablet. There is no shortage of examples. While these prices may seem modest, especially when compared to new specialty medications, it is important to remember that generics account for a significant portion of prescription drug utilization. At HPHC, for example, generics make up 86% of all prescription drug fills, and therefore the cost of these increases can add up quickly.

HPHC strongly believes price transparency is a crucial component to helping policymakers better understand the health care landscape and that these sections work to compliment the work Connecticut has done to bring transparency to medical costs. To place this importance into context please consider that for the last 2 years, prescription drug trend has outpaced outpatient, inpatient and professional medical trend. In 2016, prescription drug trend exceeded 15% (versus 8-10% medical trend), and we are projecting further increases in drug trend in 2017.

IN OPPOSITION TO SECTION 3

While HPHC very much supports sections of this legislation promoting price transparency, we are very much concerned with the sections requiring health plans to calculate coinsurance and deductible payments based on the net cost of a drug (i.e. net of negotiated rebates). HPHC believes this section, as drafted, is both unworkable and would increase insurance premiums.

Unlike other forms of medical services, all pharmacy cost-sharing is determined at the point of service. When a member purchases a drug at a pharmacy, their cost is calculated based on the negotiated discount price of the drug. Typically, this involves a copay; however, when the drug is subject to a deductible or coinsurance, the member's cost sharing is determined at the counter. Rebates negotiated between the health plan or PBM and the manufacturer, on the other hand, are not calculated until many months later. At HPHC, negotiated rebates are determined when we send pharmacy claims data to the manufacturer 45-60 days after the close of each quarter. The manufacturer analyzes the claims for eligibility, and calculates the rebate (which could be based on volume or other metrics). This makes calculating a "net" price at the point of sale impossible.

Furthermore, rebates are used in a couple of ways. Primarily, rebates are used as an offset to medical costs, which reduces premium; however, rebates may also be used pursuant to contracts between large employers and providers. For example, risk contracts between an insurer and a provider may call for the sharing of pharmacy

[1] Kantarijan H, Rajukmar SV. *Why are cancer drugs so expensive in the United States, and what are the solutions?* Mayo Clinic Proceedings. 2015; 90(4): 500-504.
[2] Howard DH, Bach PB, Berndt ER, Conti RM. *Pricing in the market for anticancer drugs*. Journal of Economic Perspectives. 2015; 29 (I); 139-162.

rebates for drugs associated with the treatment of a particular condition. Similarly, for large employers where HPHC provides administrative services as a third party administrator, rebates may be shared with the employer as an offset to administrative fees depending on how the contract is negotiated. In any case, as a not-for-profit entity, all rebates are used to the benefit of our members.

In closing, I want to again thank Comptroller Lembo and the members of this committee for taking up this important issue. As the Committee considers any action to take on this issue, however, I would respectfully ask that policymakers preserve the breadth of tools available to insurers to manage costs and utilization. Efforts to limit the use of step therapy, mandate coverage for specific drugs, set maximum cost sharing for specific prescriptions, or limit changes to health plan formularies handcuff the ability of health plans to manage these costs.

Thank you for your consideration of this testimony.